ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Application For Disability Retirement of: CYNDEE McKELVIE, Applicant/Respondent, and EL DORADO COUNTY OFFICE OF EDUCATION, Respondent.	Case No. 2013-0063 OAH No. 2015020134

PROPOSED DECISION

Ann Elizabeth Sarli, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on August 31, 2015, in Sacramento, California.

Renee Salazar, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Applicant Cyndee McKelvie represented herself.

Respondent El Dorado County Office of Education did not appear.[1]

Evidence was received and the record was closed on August 31, 2015. The ALJ reopened the record on September 17, 2015, for the purpose of admitting respondent's medical records. On September 25, 2015, respondent's medical records were filed. CalPERS filed an objection to reopening the record and objected to the admission of the medical records. CalPERS's objection to reopening the record is hereby overruled.

[1] EL Dorado County Office of Education was duly served with a Notice of Hearing. The matter proceeded as a default against this respondent, pursuant to California Government Code section 11520, subdivision (a).

Applicant's medical records were admitted in evidence pursuant to Government Code Section 11513, subdivision (d)[2]. The matter was submitted and the record was closed on September 25, 2015.

PROCEDURAL FINDINGS

1. On February 6, 2012, applicant filed a Disability Retirement Election Application (application), stating that she was unable to perform the duties of an El Dorado County Office of Education Classroom Assistant, due to reflex sympathetic dystrophy/complex regional pain syndrome.[3]

2. CalPERS obtained medical reports concerning applicant's medical condition from competent medical professionals and had applicant evaluated by an orthopedist. On the basis of the medical evidence, CalPERS determined that applicant was not permanently disabled or incapacitated from performance of her duties as a Classroom Assistant at the time her application was filed.

3. On August 15, 2012, CalPERS denied the application based upon the medical determination that applicant's orthopedic condition was not disabling.

4. Applicant wrote to CalPERS on September 4, 2012, requesting an appeal of the application denial.

5. At hearing, CalPERS submitted medical records and a report from Daniel M. D'Amico, M.D., and Dr. D'Amico testified. Cyndee McKelvie and Dan McKelvie testified. The medical records and reports of Kaiser Permanente health care practitioners and Daniel Gonzalez, M.D., were received in evidence pursuant to a post hearing order of the ALJ.

ISSUE

The issue on appeal is whether at the time she filed her application for disability retirement, applicant was permanently disabled or incapacitated on the basis of reflex

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[2] Exhibit D

[3] Applicant and her husband testified that applicant submitted a Disability Retirement application in June 2011, which CalPERS denied in September 2011. The CalPERS denial letter gave applicant an option to seek another specialist's opinion. Applicant did not receive the certified denial letter from CalPERS because the Placerville Post Office failed to deliver it. When CalPERS did not receive a response from applicant, it closed applicant's file. As found in this decision, applicant is not eligible for a disability retirement and, accordingly, the date her application was filed is not relevant in the proceedings.

sympathetic dystrophy/complex regional pain syndrome from performance of her duties as an Education Classroom Assistant for the El Dorado County Office of Education.

FACTUAL FINDINGS

Applicant's Employment

1. Applicant began working for the EL Dorado Office of Education (EDOE) in approximately 1990. She was classified as a pre-school classroom assistant. Initially she worked part-time, but over the years assumed a full-time position. According to the EDOE Class Specification for the position, she was responsible for closely supervising children ages two through five years old. She was required to stand for prolonged periods and "have significant physical abilities include[ing] lifting, carrying, pulling, stooping, kneeling, crouching, reaching, handling [and] fingering..."

2. EDOE Executive Director of Human Resources completed a CalPERS form identifying "Physical Requirements of Position/Occupational Title." The position involved never lifting over 50 pounds, lifting 11 to 50 pounds occasionally (defined as up to three hours in an eight hour day). The position also involved occasional running, climbing, reaching, pushing and pulling, fine manipulation and power grasping. The position involved frequently (defined as three to six hours in an eight hour day) sitting, standing, walking, kneeling, bending at the neck, bending at the waist, twisting at the neck, twisting at the waist, reaching below shoulder, simple grasping, repetitive use of hands, and carrying up to 25 pounds.

Application for Disability Retirement

3. In her application, applicant identified her disability as follows:

> Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome. Beginning of June 2010. Just started hurting, pain keeps getting worse.

Applicant identified her limitations as follows:

> I am in constant pain. Sitting, standing, bending and driving makes the pain level increase dramatically even after just short periods. I need to lay down to try to relieve some of the pain.

Applicant explained that she was unable to perform her job duties as follows:

> I'm unable to sit, stand, bend over, even for short periods of time without being in severe pain. I can't lift, carry or pull over

> 10 pounds. So it's impossible for me to meet the needs of the children.

Under the application section entitled "Other information you would like to provide," applicant wrote:

> I have interrupted sleep, so my head seems to be in a fog. It's hard for me to concentrate or focus on even the simplest tasks.

(Punctuation and stylistic changes made to aid readability.)

4. In her appeal letter of September 4, 2012, applicant wrote:

> Doctor Gonzales, Doctor Fenton and the Social Security Doctor and other trained staff of Social Security all said I am permanently disabled.... and they wouldn't have to review my case for another 5 to 7 years... I've been off work for two years with a doctor's note requesting that I don't work. After two months of being off of work I went back for three weeks. The pain was unbearable and the Doctor took me off again. I was taken off work by Doctor Tu 10 months before he left Kaiser and I started seeing Doctor Fenton. I've been to physical therapy and acupuncture two different times. I was put on six different medications and had five injections which resulted in many side effects. I've had CT and MRI scans, pain management classes with doctors and RNs and other tests along the way, nothing has helped the pain.... I need some help with day to day life from my family. It would be impossible for me to take care of someone else's needs. I can function with little activity, but become bedridden with pain if I'm too active...

Testimony of Applicant and Husband

5. Applicant testified that in 2010, she was having difficulty performing her duties. She was sitting in a rocking chair and could barely get up after sitting for 15 to 20 minutes. About three to four weeks later, she saw her doctor and told him that she had persistent pain that would not go away. He sent her for an MRI and she was placed on disability. Her employer held her job open for five months. She went back to work during that time and tried to work for several weeks. At that time she was working with two-year-olds eight hours a day. She had to play with them a lot on the ground and there was a lot of lifting and bending for diaper changes and toileting. She felt terrible and was unable to get out of pain. She "tried to sit or do some little things to try to get out of pain and a child would need assistance." She tried to move in different ways and that did not help her

symptoms. She found "there is no way of taking care of yourself when you're taking care of children. She was then taken off work by Doctor Tu who performed steroid injections, which did not help.

6. Applicant is now 54 years old and last worked in August 2010. Three doctors have told her she is disabled. She has been through MRIs, acupuncture, physical therapy, pain management classes and steroid injections and has taken multiple medications. When she went to be examined by Doctor D'Amico she was seen for an hour, examined for five minutes, and most of the time Doctor D'Amico talked about other cases of people that he did not feel were disabled. She has gone to every doctor appointment and every pain management class and she has more pain now than she did three years ago. She has developed depression from the pain and the lifestyle change.

7. Applicant testified that she continues to be in a lot of pain. The pain manifests across her lower back and involves the "whole hip area on the right side." Her right foot feels like it is "in snow" and it has a numb and cold feeling. It is hard for her to sit, stand or drive. Her right hip pain is so excruciating she could hardly move. The pain is constant and the things she does to relieve the pain do not give her much relief. Driving is so painful she infrequently drives. She is barely able to cook and she does few chores around the house. She tries to exercise and do yoga and tai chi to help calm her and relieve some of the pain. She has cognitive difficulties and is unable to do any of the financial things she used to do. She has depression and her "head gets so messed up and confused" when she tries to cook or do the bills. She used to take side jobs taking pictures and she used to work in her yard. Now she just stays home most of the time and tries to stay out of pain by resting and sleeping, trying herbs and oils and doing whatever the doctors recommend.

8. When asked to describe the pain, applicant testified "I just wish I could take my leg off. It's excruciating like someone pushing on it ... my foot feels like it's in snow ... I pretty much have to wear my shoes and socks where before I was barefoot a lot." Applicant is taking Norco, ibuprofen and a muscle relaxer, as well as lorazepam. She takes one Norco, two times a day, ibuprofen on an as-needed basis for headaches and a muscle relaxer two to three times a week when the pain is worse. She tries not to take the muscle relaxer because it makes her feel like she is really out of it. She takes the lorazepam once or twice a month when she feels like she really cannot handle her situation. She is taking herbs like passion flower and essential oils for depression.

9. Applicant's husband testified that they have lived together since 1978 and have been married since 1980. He has "watched her completely go down hill" as far as depression. She rests all the time and she has an electric blanket for her leg because it is always cold. She is always in pain and she tries to relieve her pain by resting and lifting her leg onto a couch or bed rather than sitting. He testified "I have watched my wife suffer miserably, she has always been a strong person." She had been responsible for the care of the children and "everything else" over the last five years when he was disabled by a heart

condition. She did the finances, grocery shopping and housekeeping. Now he does the finances because she "started to mess them up." He does 80% of the housecleaning and 90% of the cooking.

Applicant's Medical Records

10. On June 27, 2011, Dr. Gonzales, a Family Medicine Practitioner at Kaiser Permanente (Kaiser), completed a Physicians Report on Disability for CalPERS. He diagnosed applicant with lumbar radiculopathy and noted she had antalgic gait, decreased right stance, spine tenderness, pain in the low back and pain in the right hip and down the entire right leg. He noted that an MRI of the lumbar spine taken August 26, 2010 showed a right paracentral disc protrusion at L1/2. He also diagnosed applicant with sciatica, based on a positive straight leg raising, spasm, muscle tenderness and spine radiographs of October 10, 2006, which showed mild to moderate facet degeneration. He noted that applicant was seen by Dr. Joseph Tu in Physical and Rehabilitation Medicine, who had performed several steroid injections which did not provide relief of pain. He wrote that applicant's incapacity would not be permanent.

11. Applicant underwent steroid injections in March and June 2011, but did not experience pain relief. She tried different pain medications, such as Lyrica and Cymbalta, but did not tolerate them well, experiencing aggravated migraines, lightheadedness and stomach pain. She had persistent migraine and pain in her right leg, foot and hip. She underwent acupuncture and physical therapy, and did not improve. Dr. Tu diagnosed applicant with complex regional pain syndrome.

12. Applicant was moved to the care of William M. Fenton, M.D., a Kaiser physician, board certified in pain medication. On December 9, 2012, he completed a Physicians Report on Disability for CalPERS. He noted that applicant was permanently incapacitated due to complex regional pain syndrome and lumbar radiculopathy. He noted that she had low back pain along with right foot pain and pain radiating down the right leg. He noted she had a history of degeneration of the cervical spine and early degenerative joint disease of the hips.

Report and Testimony of Daniel D A'mico M.D.

13. Dr. D'Amico is board certified in orthopedic surgery and a member of the American Board of Orthopedic Surgery and the American Academy of Orthopedic Surgeon Membership. He has been licensed to practice medicine in the State of California since 1958. He has a private practice focusing on general trauma and orthopedic surgery. He is the Chief of Orthopedic Surgery at Kern Medical Center and an Assistant Professor of Clinical Orthopedic Surgery at the University of California San Diego Medical School.

14. Dr. D'Amico examined applicant on June 18, 2012, when she was 51 years old. He also reviewed her medical records relative to her complaints of low back, right

buttock and right leg pain, which began about March 2010. He produced a report, dated June 18, 2012, and testified at hearing. His report findings are summarized as follows.

15. Applicant has failed to respond to any conservative management which included medication and two physical therapy programs. The first program was once a week for five or six weeks, the second program was once a week for a few months and included an exercise program. She has work restrictions and took several medications including Cymbalta, Lyrica, Norco, Flexiril and Ibuprofen. She had two courses of acupuncture to the low back, which afforded her some temporary relief. She had an epidural steroid injection at the Caudal injection site and a piriformis injection in the posterior right buttock.

16. None of her treatments afforded applicant any permanent relief of her symptoms, specifically her low back pain at the waistline, right and left and right sacroiliac and sacrosciatic notch pain and posterior thigh and posterior lateral thigh on the right. She continued to complain of constant pain of a deep aching nature in these areas and stated she does not do any bending or lifting at home.

17. Dr. D' Amico noted that applicant had a variety of tests. X-rays of her low back and an MRI of the low back were interpreted as normal. She had an MRI of the right hip which demonstrated normal findings, except for mild arthritis. She had a electromyography (EMG) nerve conduction velocity study, which was essentially normal. She had bone density tests interpreted as being slightly decreased with osteopenia. She had a Triphasic Bone Scan,[4] which was "very minimal questionably positive" in the right foot.

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[4] "A bone scan is a nuclear scanning/imaging test or diagnostic procedure used to evaluate abnormalities involving bones and joints. The [triphasic] bone scan is part of a three-phase nuclear scan. The first phase is vascular, in which a radioactive substance (isotope) is injected intravenously and taken up in the circulation; the second phase is soft tissue, with radioactive uptake in muscles and tendons; and the third phase is bone. The isotope ... circulates throughout the body and collects preferentially in bone tissue that is growing or is, for some reason, more metabolically active. Such metabolically active sites include areas of inflammation (e.g., cellulitis, showing uptake in phases 1 and 2), injury (fractures, stress fractures), infection, and bone turnover associated with cancer .... A scanning device called a gamma camera is passed over the body to detect and record the metabolically active sites that are then imaged by a special computer .... The three-phase bone scan detects different types of pathology in the bone depending on the phase...

Phase 2, also known as the blood pool image, is obtained 5 minutes after injection. This phase will show areas with moderate to severe inflammation because of dilated capillaries that result in stagnant blood flow, allowing the radioisotope to 'pool.'

Phase 3, or the delayed phase, is the traditional bone scan. It is obtained 2 to 3 hours after the injection, when the majority of the radioisotope has been metabolized. This phase best shows the amount of bone turnover associated with the area of concern.

18. Dr. D'Amico noted that applicant had been diagnosed with complex regional pain syndrome by her treating physician at Kaiser "based on the minimally questionable positive Triphasic Bone Scan." Applicant's charts also include diagnoses of radiculitis and radiculopathy. Dr. D'Amico opined that these are not valid diagnoses because the information based on the EMG testing, MRI and physical findings did not indicate radiculopathy or radiculitis "unless of course the pain pattern can be due to one of the nerve roots. This of course has not been proven by physical findings or any of the tests that have been noted in the medical records or by the treating doctor."

19. Dr. D'Amico examined applicant and found her neck, shoulders and upper extremities were normal. She had a slight mid thoracic curve and a mild thoracolumbar curve. She had good range of motion of the back without obvious pain, muscle spasm or tenderness. Sensation in the lower extremities was intact to soft touch and pinwheel testing. She had range of motion of the low back fingertips to mid calf extension at 30° and lateral bending at 30° to the right and 30° to the left. Palpation did not reveal any spasm of the muscles, no sacrosciatic or piriformis spasm was noted from the backside but there was a claim of tenderness in the upper sacroiliac area and in the lower sacroiliac area of the sacrosciatic notch which was very minimal. She had full range of motion in the supine position with negative straight leg raising to 60° to 70°. She had normal hip flexion bilaterally and normal flexion and extension of the hip and knee. She had symmetrical circumference of both thighs and knees. Sensation to soft touch and pinwheel testing was intact throughout. Her quadriceps, hamstrings, calves and anterolateral muscle group were five/five bilaterally. Heal to toe walking was done well.

20. Dr. D'Amico opined that applicant did not have radiculopathy or radiculitis based on the review of her medical records, her physical findings and his review of the EMG/nerve velocity studies. The diagnoses of reflex sympathetic dystrophy could not be based on the Triphasic Bone Scan because it showed decreased calcification of the foot only. "This is not where her main problem is so it is very difficult to make a diagnosis of reflex sympathetic dystrophy based on this test because that is not the main problem. She only feels foot discomfort when she over uses her low back." "If her pain level is eight to 10 out of 10 as she claims, I would agree that this is disabling.... Based on her medical records, physical examination and review of all the studies she does not have any abnormalities that would indicate the reason for her pain to be eight to 10 out of 10 as she claims." "There are no test findings, physical findings, or diagnostic abnormalities that can explain this disability

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Areas of increased metabolism (activity) appear black and dark and are called 'hot spots,' whereas areas of decreased metabolism are called 'cold spots.' Hot spots may indicate healing fractures, tumor, infections, or other processes that trigger higher metabolism such as increased blood flow or new bone formation. Cold spots are indicators of decreased metabolism such as poor blood flow to an area of bone or bone destruction from a tumor. The scan is interpreted to be normal if there are no areas of increased or decreased pooling of the injected material. The normal appearance of the scan will vary according to the individual's age, but in general, a normal scan shows a uniform concentration of the isotope uptake in all bones..." (Internet Website, Reed Group MD Guidelines.)

on the anatomic, orthopedic or neurologic abnormality. The disability would be definitely related to a severe somatoform or a reflex complex soft tissue pain problem." "Based on the physical exam and review of medical findings she is able to perform lifting and bending and is not presently incapacitated for the performance of her duties."

21. Dr. D'Amico testified at hearing. He explained that he could not substantiate the diagnosis of complex regional pain syndrome. He reiterated that his physical examination of applicant was normal, with the exception that applicant reported very slight tenderness in the upper sacroiliac and sacro-sciatic notch. Her MRI was normal and there were no significant arthritic changes in the sacroiliac joint. Her flexion and extension of the back was "not particularly abnormal or particularly painful." Range of motion of her hip joint indicated that "she does not have a hip joint that is abnormal enough to affect her motion." Straight leg raising was negative, indicating she did not have nerve root irritation. Both motor and sensory nerve root function was normal. Her strength was not affected appreciably by anything emanating from the muscles or nerves. The physical exam "was totally benign in the sense one could not from the physical exam alone make a diagnosis that involved any injury ... [Affecting] muscles or the nerves emanating from the back and going down the leg." He opined that "one can only state she had subjective pain."

22. In respect to the diagnosis of radiculopathy or radiculitis, Dr. D'Amico noted that his testing of applicant and the medical records of Kaiser substantiate that applicant has normal range of back motion and reflexes and symmetric measurements without atrophy. The records from Kaiser did not show any weakness. Dr. D'Amico noted that eventually Kaiser dropped the reference to radiculopathy and radiculitis in its records and substituted a pain diagnosis.

23. In respect to the diagnosis of complex regional pain syndrome, Dr. D'Amico testified that a chronic pain syndrome would "first of all require an injury." The onset would occur upon any type of soft tissue injury, however minimal. He has had cases where someone hit themselves in the hip and became totally disabled. Here, according to applicant's medical records, the history of the onset was gradual. And according to the AMA Industrial Guidelines the diagnosis is dependent on the patient manifesting eight out of 11 symptoms including: unexplained persistent pain, allodynia, a sensitivity where the patient's skin is very sensitive to touch; neurovascular phenomena, tissue edema, cool skin temperature or profuse sweating, motor weakness and decreased range of motion.[5]

24. Dr. D'Amico testified that a triphasic bone scan can support a diagnosis of complex regional pain syndrome when it shows osteoporosis or osteopenia in the area of pain. Applicant's triphasic bone scan was normal except for a positive finding in the right foot. She had previously had bunion surgery on that foot and could have had foot pain consequent to the surgery. However if the right foot bunion surgery was regarded as an injury, the injury has to emanate immediately and progressively and has to follow a set

[5] Dr. D'Amico did not provide a comprehensive listing of the 11 symptoms discussed in the AMA Industrial Guidelines.

pattern from the foot. The pain would not occur in the back or the leg. However, Dr. D'Amico then stated that it is possible the pain could radiate up the leg from an injury in the foot, however there would have to have been other findings that were document in the reports or in his exam. The areas of her back which were scanned were normal.

25. Based on his education and experience, review of the medical records and examination of applicant, Dr. D'Amico formed the opinion that applicant is not substantially incapacitated for the performance of her duties due to an orthopedic condition.

Discussion

26. Applicant's medical evidence supporting her claim for disability was slight. Only Dr. Fenton's report found applicant was permanently incapacitated from work. Dr. Fenton did not testify, and his report came into evidence as hearsay. Dr. Fenton's report does not on its face substantiate the cause of applicant's pain. His report carried over the diagnoses of complex regional pain syndrome and lumbar radiculopathy from other medical records, but, as Dr. D'Amico pointed out, there was no evidence substantiating these diagnoses. Degeneration, of the cervical spine and hips was normal for applicant's age and she had no nerve root impingement on MRI or test results that substantiated radiculopathy. Dr. Fenton provided no objective findings for the diagnosis of complex regional pain syndrome.

27. Additionally, although Dr. D'Amico acknowledges that applicant does have pain, he testified persuasively that she does not have the conditions of regional pain syndrome and lumbar radiculopathy. He found no objective basis for the nature and amount of disability and pain she reports.

28. Applicant has the burden of proving by a preponderance of the evidence that at the time she filed her application she suffered from Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome to the extent that she was substantially incapacitated from the performance of her job duties. Her reports of pain and disability are unsupported by the medical evidence and, accordingly, she has failed to meet her burden of proof.

LEGAL CONCLUSIONS

1. By virtue of her employment with El Doardo County, applicant is a local miscellaneous member of CalPERS subject to Government Code section 21150.[6]

2. Section 21152 provides in pertinent part:

> Application to the board for retirement of a member for disability may be made by:

[6] All statutory references are to the Government Code unless otherwise stated.

[¶] ... [¶]

(d) The member or any person in his or her behalf.

3. Section 21154 provides in pertinent part:

> The application shall be made only (a) while the member is in state service .... On receipt of an application for disability retirement of a member ... the board shall, or of its own motion it may, order a medical examination of a member who is otherwise eligible to retire for disability to determine whether the member is incapacitated for the performance of duty ....

4. Section 21156, provides in pertinent part:

> (a)(1) If the medical examination and other available information show to the satisfaction of the board ... that the member in the state service is incapacitated physically or mentally for the performance of his or her duties and is eligible to retire for disability, the board shall immediately retire him or her for disability, unless the member is qualified to be retired for service and applies therefor prior to the effective date of his or her retirement for disability or within 30 days after the member is notified of his or her eligibility for retirement on account of disability, in which event the board shall retire the member for service.

5. Section 20026 provides in pertinent part:

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board ... on the basis of competent medical opinion.

6. "Incapacity for the performance of duty" under Government Code section 21022 [now section 21151] "means the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) Substantial inability to perform usual duties must be measured by considering applicant's abilities. Discomfort, which makes it difficult to perform ones duties, is insufficient to establish permanent incapacity from performance of one's position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, citing *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 862.) A condition or injury that may increase the likelihood of further injury, as well as a fear of future injury, do not establish a present "substantial inability" for the purpose of receiving disability retirement. (*Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal. App. 3d 854,

863-864.) As the court explained in *Hosford*, prophylactic restrictions imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature.

7. An applicant for disability retirement must submit competent, objective medical evidence to establish that, at the time of application, he or she was permanently disabled or incapacitated from performing the usual duties of his or her position. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697.)

8. Findings issued for the purposes of another compensation system are not evidence that respondent's injuries are substantially incapacitating for the purposes of disability retirement. (CF *Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207; *English v. Board of Administration of the Los Angeles City Employees' Retirement System* (1983) 148 Cal.App.3d 838, 844.)

9. The burden of proof is upon applicant to show that she is permanently and substantially unable to perform her usual duties such that she is permanently disabled. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal. App. 3d 689; *Glover v. Board of Retirement* (1980) 214 Cal. App. 3d 1327, 1332.) Applicant has not met that burden, by virtue of the Factual Findings and Legal Conclusions.

10. As set forth in the Factual Findings and Legal Conclusions, applicant is not permanently and substantially disabled or incapacitated from the performance of her job duties and, therefore, is not entitled to disability retirement.

ORDER

1. Cyndee McKelvie's appeal of the CalPERS determination that she is not eligible for disability retirement is DENIED.

2. Cyndee McKelvie's application for disability retirement is DENIED.

DATED: October 22, 2015

DocuSigned by:
Ann Sarli
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ANN ELIZABETH SARLI
Administrative Law Judge
Office of Administrative Hearings